State of Vermont WIC Program

MEDICAL DOCUMENTATION FOR WIC FORMULA AND APPROVED WIC FOODS

WOMEN

1. Patient's Name: _____Date of Birth: __/___ /___

Prescription is subject to WIC approval and provision is based on Program policy and procedure.

2. Please check qualifying medical condition(s)/ICD-9 code(s)

- ☐ 693.1 Allergy, Food [cow's milk protein, soy]
- ☐ 343.9 Cerebral Palsy
- ☐ 250.01Diabetes Mellitus Type I
- ☐ 271.1 Galactosemia
- ☐ 279.3 Immunodeficiency
- ☐ 646.8 Low Maternal Weight Gain
- ☐ 783.2 Maternal Weight Loss During Pregnancy
- ☐ 651 Multifetal Gestation
- ☐ 358.9 Neuromuscular Disorder
- ☐ 270.1 Phenylketonuria (PKU)
- ☐ 271.3 Lactose Intolerance
- ☐ _____ Other diagnosis with ICD-9 code
  Specify _____

3. Formula or medical food requested:_____

Prescribed amount per day* _____ OR ☐ ad lib

Product form: ☐ Powder ☐ Concentrate ☐ Other:

Length of use: ☐ During pregnancy ☐ Postpartum/Breastfeeding

Special instructions: _____

***WIC is a supplemental nutrition program and may not provide the total amount of formula or food prescribed**

4. WIC Supplemental Foods Available

The patient will receive supplemental foods in addition to the formula indicated. Please indicate if **all foods are allowed** or indicate any supplemental foods **contraindicated** by the patient's medical diagnosis.

☐ All foods are allowed

OR

Foods contraindicated:

- ☐ Breakfast cereal
- ☐ Eggs
- ☐ Beans
- ☐ Peanut butter
- ☐ Milk
- ☐ Cheese
- ☐ Juice
- ☐ Vegetables and Fruits
- ☐ Whole grain bread
- ☐ Brown rice
- ☐ Soy products
- ☐ Tuna

Intended length of use: ☐ During pregnancy ☐ Postpartum/Breastfeeding

5. WIC Authorization:

☐ By checking this box, I authorize the WIC Nutrition Professional to determine any future appropriate supplemental foods and amounts, ***excluding*** formula/medical foods.

6.	**HEALTH CARE PROVIDER SIGNATURE** (MD, APRN or PA):	**Date:**

Printed Name or Stamp (Health Care Provider):

Medical Office/Clinic/Hospital: Phone:

Address: Fax:

Instructions for Physicians or Physician Assistants or Nurse Practitioners

(Only Healthcare Providers licensed to write a prescription in Vermont can complete this form)

Item #1: Write patient's complete name and date of birth.

Item #2: From the list of most common nutrition related ICD-9 medical diagnoses determine and document one or more of the patient's serious qualifying medical condition(s) for which WIC prescriptions may be written. Other medical diagnosis that may require formulas or medical foods must have an ICD-9 diagnosis code and will be considered on a case by case basis.

Item #3: Indicate the formula or medical food requested, any special instructions and the intended length of use. It is WIC's policy to re-evaluate the participant's continued need for the formula on a periodic basis. Physical forms routinely provided by WIC are powder or concentrate. Ready-to-Feed (RTF) formula or medical foods may be authorized when the product is only available in ready-to-feed, when WIC nutrition staff determines and documents that there is an unsanitary or restricted water supply or poor refrigeration, or the participant has difficulty in correctly diluting the concentrated liquid or powdered formula.

Item #4 The patient will receive supplemental foods from the WIC Program, appropriate to their participant category in addition to the formula indicated. Please indicate if **all foods are allowed** or indicate any supplemental foods **contraindicated** by the patient's medical diagnosis. Prescription renewal may be required periodically, based on medical condition.

Item #5 Providing **WIC Authorization** allows the WIC Nutrition Professional to determine any future additions or subtractions to the supplemental foods provided by the WIC Program. This authorization does not include medical formulas or medical food.

Item #6 A Health Care Provider's **signature** is required. Print or stamp your name, medical office, phone number and address. By signing this form, you are verifying you have seen and evaluated the patient's nutrition and feeding problem(s) and symptoms determining she has a serious medical condition. Give the completed form to the patient to take to their local WIC program or fax or mail to the WIC office serving the patient.

For more information or additional copies of this form visit the Vermont Health Department website at http://www.healthvermont.gov/wic/providers.aspx

WIC Office Use: **WIC Staff Signature:** _____ **Date:** _____
WIC Staff instructions: Review form for completeness. If there are questions, before approving the prescription, contact the participant's health care provider to resolve. Sign and date form.

WIC is an equal opportunity provider.